FRANKLIN COUNTY ACCIDENT REPORT FORM for INJURED EMPLOYEES (ARFIE)

rev. 9-1-02

AGENCY FUND/ORG NO.:	FRANKLIN COUNTY RISK NO. 32500001-0	BWC CLAIM NO. (RM USE ONLY)

EMPLOYEE'S INFORMATION:

EMPLOYEE NAME:	EMPLOYEE S.S. NO:	DEPARTMENT OR AGENCY:	
HOME ADDRESS:	HOME TELEPHONE:	AGE:	Birth Date
CITY, COUNTY, STATE, ZIP CODE	WORK TELEPHONE:	OCCUPATION:	

ACCIDENT INFORMATION COMPLETED BY SUPERVISOR AND/OR INJURED EMPLOYEE

LOCATION OF ACCIDENT OR INJURY:	INJURY DATE:	INJURY TIME: AM PM
Was injury on County Property? Yes ☐ No ☐	REPORT DATE:	WORK SHIFT:
Job Duties being perform at time of injury:	SUPERVISOR	CONTACT PERSON
DID INJURED EMPLOYEE RETURN TO WORK ? Yes ☐ No ☐	DID EMPLOYEE GO FOR MEDICAL TREATMENT? YES ☐ NO ☐	SUPERVISOR'S PHONE NO.
DESCRIBE ACCIDENT: In your own words, explain in detail how accident occurred:		

INJURED BODY PART (S)
example: left arm, right index finger, upper left thigh)

1 _____

2 _____

3 _____

4 _____

5 _____

I certify by my signature that the information on this injury report is true and complete to the best of my knowledge.

Employee Signature	Date
X	

This is my description of the accident. As provided by Section 4123.651-c of the Ohio Revised Code, I hereby permit the release of medical information, records and reports, relative to the issues necessary for the administration of my Workers' Compensation claim to the Industrial Commission, the Ohio Bureau of Workers' Compensation, the employer and its authorized representative, CompManagement Health Systems, as such medical information, records and reports may possibly pertain to a condition either alleged or allowed in my claim or to consider payment or to determine the eligibility of payment of compensation and medical benefits under my Workers' compensation claim.

X	Date

Employee must sign two times-one signature to describe occurrence and one to authorize release of medical records.

ACCIDENT INFORMATION COMPLETED BY INJURED WORKER AND/OR SUPERVISOR

1. Did employee seek medical attention for the injuries sustained?
   Yes ☐ No ☐
   If yes, list the doctor and/or the medical provider:

Doctor or Medical Provider :		Telephone:	
Address	City:	State:	Zip Code:

   Is this doctor/medical provider your family physician? Yes☐ No☐
2. Did any other employee or person witness the accident or injury?
   Yes☐ No ☐
   If yes, list their names below:

1.	3.
2.	4.

3. Was more than one person injured in this accident? Yes☐ No ☐
   If yes, provide their names:

1.	3.
2.	4.

4. Was any work place machinery or equipment involved?
   Yes ☐ No☐
5. If your answer is "yes". Please provide the following information:

TYPE OF EQUIPMENT:	MANUFACTURER:	EQUIPMENT'S AGE:	MODEL NO.:
HAS MACHINE BEEN MODIFIED ?: YES ☐ NO☐	HOW?	WHY?	SERIAL NO:

6. Was there mechanical failure? Yes ☐ No☐
7. If "yes", please describe:

8. Was the injury caused by any outside contractor or repair company(s)?
   Yes☐ No☐

9. If so, please answer the following:

NAME OF FIRM:	STREET ADDRESS	CITY, STATE, ZIP	CONTACT PERSON	TELEPHONE

10. Was this injury the result of an automobile accident? Yes☐ No☐

11. If you answered yes to Question 10, were you cited for any moving violation(s)? Yes☐ No☐

If you answered yes to Question 10, you are required to provide a copy of the local police auto accident report.

12. Was the injury a result of **lifting or handling objects**? Yes☐ No☐

13. I you answered yes to question 12, what was the approximate weight of the object handled? _____ pounds

14. How did you lift the object? _____

15. Did anyone help you lift the object? Yes☐ No☐ If yes, who?_____

ENVIRONMENTAL CONDITIONS (if applicable): SURFACE: LIGHT: OTHER ENVIRONMENTAL FACTORS:	WORKING OVERTIME? YES NO ☐ ☐ ON COUNTY'S PREMISES? YES NO DID EMPLOYEE RETURN TO WORK? YES NO ☐ ☐ IF YES, WHEN?	AUTO ACCIDENT YES NO ☐ ☐ ATTACH POLICE REPORT IF "YES" COUNTY OWNED VEHICLE? YES NO ☐ ☐ HAS INJURED PERSON TAKEN THE SHERIFF'S DEFENSIVE DRIVING COURSE? YES NO ☐ ☐

Reported to CompManagement Health Systems By:	Date and Time:	Phone☐ Fax ☐ Both☐

Supervisor's Section

I have reviewed this accident report and am aware of the details of the accident. (You may comment on or dispute any or all of the injured employee's statements or accident description below or on separate paper.)

SUPERVISOR'S SIGNATURE :	**Date:**
Director or Administrator's Signature	**Date:**

Print **Reset**